Nevada State Board of Dental Examiners
6010 S. Rainbow Blvd., Bldg. A, Ste. 1
Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

GENERAL ANESTHESIA / DEEP SEDATION
INSPECTION AND EVALUATION
☐ SITE/ADMINISTRATOR EVALUATION ☒ SITE ONLY INSPECTION

Name of Practitioner: Dr. X	Proposed Dates:
Location to be Inspected:	Telephone Number:
Date of Evaluation:	Time of Evaluation:

Evaluators

1.
2.
3.

INSTRUCTIONS FOR COMPLETING GENERAL ANESTHESIA/DEEP SEDATION INSPECTION AND EVALUATION FORM:

1. Prior to inspection/evaluation, review criteria and guidelines for General Anesthesia (GA)/Deep Sedation (DS) Inspection and Evaluation in the Examiner Manual.

2. Each evaluator should complete a GA/DS Site/Administrator Evaluation or Site Only Inspection form independently by checking the appropriate answer box to the corresponding question or by filling in a blank space.

3. Answer each question. (For Site Only Inspections, complete Sections A, B, and D)

4. After answering all questions, each evaluator should make a separate overall "pass" or "fail" recommendation to the Board. "Fail" recommendations must be documented with a narrative explanation.

5. Sign the inspection/evaluation report and return to the Board office within ten (10) days after inspection/evaluation has been completed.

A. OFFICE FACILITIES AND EQUIPMENT

1. Operating Theater	YES	NO
a. Is operating theater large enough to adequately accommodate the patient on a table or in an operating chair?	✓	
b. Does the operating theater permit an operating team consisting of at least three individuals to freely move about the patient?	✓	
2. Operating Chair or Table		
a. Does operating chair or table permit the patient to be positioned so the operating team can maintain the airway?	✓	
b. Does operating chair or table permit the team to quickly alter the patient's position in an emergency?	✓	
c. Does operating chair or table provide a firm platform for the management of cardiopulmonary resuscitation?	✓	
3. Lighting System		
a. Does lighting system permit evaluation of the patient's skin and mucosal color?	✓	
b. Is there a battery powered backup lighting system?	✓	
c. Is backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?	✓	
4. Suction Equipment		
a. Does suction equipment permit aspiration of the oral and pharyngeal Cavities?	✓	
b. Is there a backup suction device available which can operate at the time of General power failure?	✓	
5. Oxygen Delivery System		
a. Does oxygen delivery system have adequate full face masks and appropriate connectors and is capable of delivering oxygen to the patient under positive pressure?	✓	
b. Is there an adequate backup oxygen delivery system which can operate at the Time of general power failure?	✓	
6. Recovery Area (Recovery area can be operating theater)		
a. Does recovery area have available oxygen?	✓	
b. Does recovery area have available adequate suction?	✓	
c. Does recovery area have adequate lighting?	✓	
d. Does recovery area have available adequate electrical outlets?	✓	

7. **Ancillary Equipment in Good Operating Condition?**	**YES**	**NO**
a. Are there oral airways?	✓	
b. Is there a tonsilar or pharyngeal type suction tip adaptable to all office outlets?	✓	
c. Is there a sphygmomanometer and stethoscope?	✓	
d. Is there adequate equipment for the establishment of an intravenous infusion?		✓
e. Is there a pulse oximeter?	✓	
f. A laryngoscope complete with an adequate selection of blades and spare batteries and bulbs?	✓	
g. Endotracheal tubes and appropriate connectors?	✓	
h. An endotracheal tube type forcep?	✓	
i. An electrocardioscope and defibrillator?	✓	

B. RECORDS – Are the following records maintained?

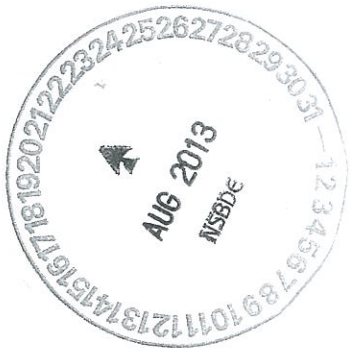
1. An adequate medical history of the patient?	✓	
2. An adequate physical evaluation of the patient?		✓
3. Anesthesia records show blood pressure reading?	✓	
4. Anesthesia records show pulse reading?	✓	
5. Anesthesia records listing the drugs administered, amounts administered, and time administered?		✓
6. Anesthesia records reflecting the length of the procedure?		✓
7. Anesthesia records reflecting any complications of the procedure, if any?		✓
8. Written informed consent of the patient, or if the patient is a minor, his or her parent or guardian's consent for administration of anesthesia?		✓

C. DEMONSTRATION OF GENERAL ANESTHESIA / DEEP SEDATION

	YES	NO
1. Who administered General Anesthesia / Deep Sedation? Dentist's Name:		
2. Was case demonstrated within the definition of general anesthesia / deep sedation?		
3. While anesthetized was patient continuously monitored during the procedure with a pulse oximeter and other appropriate monitoring equipment? If not, what type of monitoring was utilized?		
4. Was the patient monitored while recovering from anesthesia? Monitored by whom:		
5. Is this person a licensed health professional experienced in the care and resuscitation of patients recovering from general anesthesia / deep sedation?		
6. Were personnel competent?		
7. Are all personnel involved with the care of patients certified in basic cardiac life support?		
8. Was dentist able to perform the procedure without any action or omission that could have resulted in a life threatening situation to the patient?		
9. What was the length of the case demonstrated?		

D. DRUGS

	DRUG NAME	EXPIRES	YES	NO
1. Vasopressor drug available?	Ephedrine	3-2016	✓	
2. Corticosteroid drug available?	Solu-cortef	12-17	✓	
3. Bronchodilator drug available?	Albuterol	8-14	✓	
4. Appropriate drug antagonists available?	Naloxone Flumazinil	1-2015 2-2014	✓ ✓	

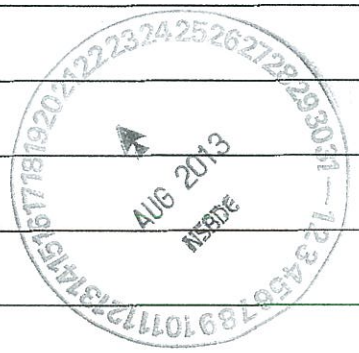


	DRUG NAME	EXPIRES	YES	NO
5. Antihistaminic drug available?	Diphenhydramine	10-14	✓	
6. Anticholinergic drug available?	Atropine	3-15	✓	
7. Coronary artery vasodilator drug available?	Nitro	6-15		
8. Anticonvulsant drug available?	Diazepam	3-14		
9. Oxygen available?	O2			
10. Muscle relaxant?	Succinylcholine	3-14		
11. Antiarrhythmic?	Adenosine Amiodarone	3-14 6-14		
12. Antihypertensive?	Labetalol	2-1-15		
13. Intravenous medication for the treatment of cardiopulmonary arrest?	Verapamil	7-1-15		

E. SIMULATED EMERGENCIES – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of:

	YES	NO
1. Airway obstruction laryngospasm?		
2. Bronchospasm?		
3. Emesis and aspiration of foreign material under anesthesia?		
4. Angina pectoris?		

5. Myocardial infarction?		
6. Hypotension?		
7. Hypertension?		
8. Cardiac arrest?		
9. Allergic reaction?		
10. Convulsions?		
11.Hypoglycemia?		
12.Asthma?		
13.Respiratory depression?		
14.Allergy to or overdose from local anesthesia?		
15.Hyperventilation syndrome?		
16.Syncope?		



Evaluator Overall Recommendation
☐ Pass ☑ Fail

Comments: NO ANESTHESIA RECORDS NO INFORMED CONSENT SEPARATE AND SPECIFIC TO GENERAL ANESTHESIA

Signature of Evaluator _____ Date _____

undefined

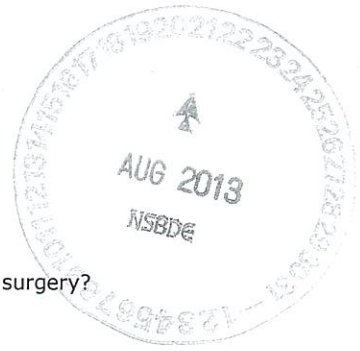
Medical Release Form

Patient: SPECIAL MESSAGE
Chart Numbe
Date

Dear Doctor,
I examined your patient, **SPECIAL MESSAGE**, medical record# **1234560** on **08/16/2013** and recommended the following dental treatment

Before proceeding, we would like to be sure that the patient is able to be treated safely. Please fill out each category that applies to patient:

- Does patient have diabetes? **YES** or **NO**
  - If yes, is patient **insulin dependent** or **non-insulin dependent**? (please circle)
- Does patient have a history of heart attack or stroke? **YES** or **NO**
  - If yes, can patient have general anesthesia or IV sedation?_____
  - If patient cannot have general anesthesia, which of the following is recommended:
    - local anesthetic with epinephrine **or**
    - local anesthetic without epinephrine
- Does patient have asthma? **YES** or **NO**
  - When was patient's last attack?_____ How frequent are the attacks? _____
  - Was hospitalization required? **YES** or **NO**
  - Does patient have Chronic Obstructive Pulmonary Disease? **YES** or **NO**
- Does patient have High Blood Pressure? **YES** or **NO**
- Is HBP controlled by medication? **YES** or **NO**
  - Which one?_____
- Patient is schedule for Intravenous Sedation using the following medications. Are there any contradictions to using the following medications?
  - Robinul 0.2mg **YES** or **NO**
  - Fentanyl 25 g to 50 g **YES** or **NO**
  - Versed 2 – 5mg **YES** or **NO**
  - Propofol 20 – 100mg **YES** or **NO**
  - Ketamine 12.5 – 25mg **YES** or **NO**
  - Decadron 8mg **YES** or **NO**
- Is patient on any of the following "blood thinners"?
  - Coumadin____
  - Aspirin____
  - Plavix____
  - INR____
  - PT/PTT____
- How many days should patient discontinue use of "blood thinners" before surgery? (Doctor would prefer at least 7 days)_____
- Does patient have a heart murmur? **YES** or **NO**
- Is patient HIV positive? **YES** or **NO**
  - Undergoing treatment? **YES** or **NO**
- Is premedication needed for any reason? **YES** or **NO**
  - What antibiotic is recommended?_____
  - Please list all medications patient is currently taking? _____ _____



_____ _____ _____
Physician's Signature Phone Number# Emergency#

I **SPECIAL MESSAGE** hereby authorize my Physician to release any pertinent facts regarding my medical condition to the dentist named below,_____
Patient Signature
_____, DDS
Dentist's Signature

Patient name: SPECIAL MESSAGE **Date Created:** 08/16/2013

We would like to get to know you better!

Marital Status --Select one-- DOB 12/25/1999

Requested help to complete form Yes ○ No ○

Occupation

Employer

Work Schedule --Select one--

Drivers License #

Emergency Contact

Contact Phone #

Heard about us --Select one--

Last Dental appointment --Select one--

Left last Dentist --Select one--

Financially responsible

We want to take care of your needs...

Current dental problems		Avoid brushing part of mouth	Yes ○ No ○	Dissatisfied with teeth / appearance	Yes ○ No ○
Nervous about dental treatment	--Select one--	Longer lasting solutions	Yes ○ No ○	Whiter teeth	Yes ○ No ○
Dental health	--Select one--	Straighter teeth	Yes ○ No ○	Close spaces in teeth	Yes ○ No ○
Repair chips in teeth	Yes ○ No ○	Sensitive to sweets, hot/cold or biting	Yes ○ No ○	Interested in replacing mercury/amalgam/silver fillings	Yes ○ No ○
Other concerns / needs					

Medical History

Good health	Yes ○ No ○	Change in general health	Yes ○ No ○	Last physical exam	--Select one--
Serious illness or operation	Yes ○ No ○			Tumor, growth / other of the mouth or lips	Yes ○ No ○
Care of a physician	Yes ○ No ○	Condition being treated		Physician name and address	
Blood transfusion	Yes ○ No ○	Circumstances		Hospitalized/Serious illness past five years	Yes ○ No ○
Serious problems with previous dental work:	Yes ○ No ○	Please describe problem		Abnormal bleeding with extractions, surgery or trauma	Yes ○ No ○
Implants and/or prothesis	Yes ○ No ○	Do you smoke or use tobacco products	Yes ○ No ○	How much do you smoke	--Select one--
Thirsty much of the time	Yes ○ No ○	Mouth frequently becomes dry	Yes ○ No ○	Gums bleed when brush	Yes ○ No ○
Does your jaw pop or click when opening or chewing?	Yes ○ No ○	Has your jaw ever been stuck open or closed?	Yes ○ No ○		

Gender Specific Questions

Male ○ Female ○

Pregnant or could you be Yes ○ No ○

When are you due?

Are you nursing? Yes ○ No ○

Are you currently taking oral contraceptives? Yes ○ No ○

Specialist Specific Questions

Height: ft in

Weight: lbs

Do you have Porphyria (blood disorder)? Yes ○ No ○

Have you or anyone else in your family had malignant hyperthermia or other complications while under general anesthesia? Yes ○ No ○

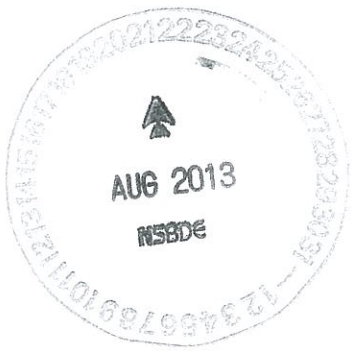
Do you have habits such as nail biting, pencil biting, or lip biting? Yes ○ No ○

Do you have habits such as thumb sucking or mouth breathing? Yes ○ No ○

Do you clench or grind your teeth? Yes ○ No ○

Have your wisdom teeth been extracted? Yes ○ No ○

When were they extracted?



Drugs or Medications

Are you taking any drugs or medications? Yes ○ No ○

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (blood thinners)
- ☐ Digitalis or drugs for heart trouble
- ☐ Insulin, tolbutamide(Orinase), or similar drug
- ☐ Hormone therapy/replacement
- ☐ Aspirin
- ☐ Medicine for high blood pressure
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Recreational or non-prescribed drugs
- ☐ Tranquilizers
- ☐ Osteoporosis, chemotherapy or multiple myeloma medications such as Actonol, Boniva, Fosomax, Skelid and Bonefos
- ☐ Fen-Phen (now or in the past) or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux(dexfenfluramine)

Other

Existing medical conditions

Heart Yes ○ No ○ (ex. Heart attack, Heart murmur and High blood pressure)

- ☐ Heart transplant
- ☐ Cardiovascular disease (heart trouble, heart attack, coronary occlusion, arteriosclerosis)
- ☐ Congestive Heart failure

- [ ] Myocardial infarction
- [ ] Rheumatic fever or rheumatic heart disease
- [ ] Heart murmur/MVP - Mitral Valve Prolapse
- [ ] High Blood pressure
- [ ] Low blood pressure
- [ ] Heart surgery, Bypass, Stents
- [ ] Artificial Heart valves
- [ ] Pacemaker
- [ ] Stroke

Other

Lungs Yes ○ No ○ (ex. Emphysema, Asthma and Bronchitis)

- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Asthma
- [ ] Bronchitis
- [ ] Hay fever
- [ ] Chronic cough
- [ ] Difficulty breathing

Other

Liver Yes ○ No ○ (ex. Hepatitis)

- [ ] Hepatitis A (infectious)
- [ ] Hepatitis B (serum)
- [ ] Hepatitis C
- [ ] Jaundice or Liver disease

Other

Kidney Yes ○ No ○ (ex. Dialysis)

- [ ] Kidney transplant
- [ ] Dialysis treatment
- [ ] Frequent urination

Other

Gastrointestional Yes ○ No ○ (ex. Ulcers, Reflux and Gastric Bypass)

- [ ] Ulcers
- [ ] Diverticulitis
- [ ] Bowel problems
- [ ] Gastric Bypass
- [ ] Reflux/Heartburn GERD
- [ ] Eating Disorder

Other

Blood / Endocrine Yes ○ No ○ (ex. AIDS, Anemia and Diabetes)

- [ ] AIDS or HIV+
- [ ] Hemophilia
- [ ] Sickle Cell disease
- [ ] Diabetes
- [ ] Hypoglycemia
- [ ] Anemia
- [ ] Thyroid
- [ ] Sexually transmitted diseases

Other

Mental Health/Nervous Disorders Yes ○ No ○ (ex. Epilepsy, Anxiety and ADHD/ADD)

- [ ] Depression
- [ ] Sleep disorder
- [ ] Epilepsy/Seizures
- [ ] Fibromyalgia
- [ ] Mental Health problems
- [ ] Schizophrenia
- [ ] Anxiety
- [ ] Bi-polar
- [ ] Autism
- [ ] ADHD/ADD Attention Deficit

Other

Other Yes ○ No ○ (ex. Cold sores, Chemotherapy and Arthritis)

- [ ] Cancer
- [ ] Sinus trouble
- [ ] Cold sores
- [ ] Radiation therapy
- [ ] Chemotherapy
- [ ] Severe headaches/Migraines
- [ ] Delayed healing
- [ ] Contact lenses
- [ ] Chronic fatigue
- [ ] Inflammatory rheumatism (painful, swollen joints)
- [ ] Arthritis

Other

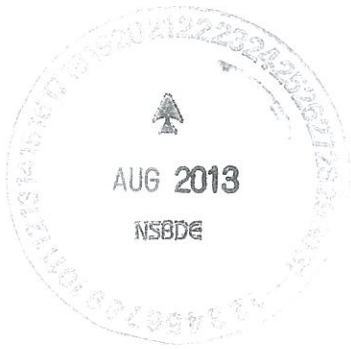
Allergies

Do you have any allergies or have you reacted adversely to anything in the past Yes ○ No ○

- [ ] Local anesthetic
- [ ] Aspirin
- [ ] Penicillin or other antibiotics
- [ ] Codeine or other narcotics
- [ ] Iodine
- [ ] Barbiturates, sedatives, or sleeping pills
- [ ] Latex
- [ ] Hives or skin rash
- [ ] Sulfa drugs
- [ ] Asthma or hay fever
- [ ] Metal
- [ ] Eggs
- [ ] Soybean

Other

Dr. Notes



Patient Signature:	No Signature Available Parent/Guardian Signature if Minor

undefined

Oral Surgery Statement of Consent

Patient: SPECIAL MESSAGE
Chart Number: 1234560
Date: 08/16/2013

1. I hereby authorize to treat the condition(s) described below.

2. The procedure(s) necessary to treat the condition(s) have been explained to me. I understand the nature of the procedure and I agree to undergo the following treatment/procedure/surgery:

3. The alternatives to treat the condition(s), including no treatment, have been explained to me. I have had the opportunity to discuss these alternatives with and/or staff to my full satisfaction.

4. I understand that in some cases, this may be an elective procedure and that my doctor has informed me of alternative treatment or no treatment at all.

5. I understand that some insurance companies consider intravenous sedation or general anesthesia an elective procedure. I agree to be financially responsible for charges incurred for this service if my insurance company does not cover them.

6. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to, the following:

   - ☐ A. Injury to adjacent teeth and fillings. **If injury or damage to adjacent teeth and/or fillings occurs from this procedure, all costs to repair or replace such injured or damaged fillings and/or teeth are my responsibility.**
   - ☐ B. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
   - ☐ C. Heavy bleeding that may be prolonged.
   - ☐ D. Postoperative infection requiring additional treatment.
   - ☐ E. Stretching of the corners of the mouth with the resultant cracking and bruising.
   - ☐ F. Restricted mouth opening for several days or weeks.
   - ☐ G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
   - ☐ H. Breakage of the jaw.
   - ☐ I. Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue on the operated side; this may persist for several weeks, months or in remote instances, permanently.
   - ☐ J. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
   - ☐ K. If intravenous medication is used, soreness at injection site or along the vein may develop as well as some discoloration of the injection site.
   - ☐ L. Anesthetic complications may include nausea, vomiting, allergic reactions, respiratory, circulatory, hyper/hypo tension, and cardiac arrest.
   - ☐ M. Other:

7. It has been explained to me that during the course of the procedure unforeseen conditions may originally reveal that necessitate an extension of the original treatment procedure(s) or

different treatment procedure(s) than those set forth above. I therefore authorize and request that perform such procedures as are necessary and desirable in the exercise of professional judgment, and to treat or correct any unexpected conditions found or problems occurring during the treatment, procedure, or surgery. The authority granted should extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

8. SPECIALISTS ARE INDEPENDENT CONTRACTORS: Specialists furnishing services to the patient, including the oral surgeon are independent contractors and are not employees or agents of the office. The patient is under the care and supervision of his/her specialist and it is the responsibility of the office to carry out the instructions of a specialist. It is the responsibility of the specialist to obtain the patient's informed consent when required, for specialist dental treatment, including diagnosis, and for office services rendered the patient under the general and special instructions of the specialist.

9. I consent to the use of local, nitrous oxide, intravenous sedation, or general anesthesia. I understand that the use of anesthesia poses inherent risks including vein inflammation (phlebitis), serious permanent injury, and death. I have, or will have, abstained from eating and drinking fluids for eight hours prior to the anesthesia. I have not taken, and will not take undisclosed medications or drugs prior to treatment/surgery. I have not taken any recreational or street drugs.

   I am allergic to _____. I have accurately reported my complete health history.

10. Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination; which can be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications and/or drugs, or until fully recovered from the effects of the treatment. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital. I agree not to drive myself home after surgery and will have a responsible adult drive to and from surgery. The driver will stay with me for several hours until I have recovered sufficiently to care for myself if I have received any sedative medications.

11. It has been explained to me and I understand that a perfect result is not and cannot be guaranteed or warranted.

12. I certify that I read and write English and have read and fully understand this "Oral Surgery Statement of Consent."

PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

By signature below I confirm that I have checked the boxes above and that by checking same I confirm that I have read the foregoing sections and understand the treatment to be undertaken, as well as the risks, benefits, and alternatives and consent to the described treatment.

Patient/Guardian's Signature:	No Signature Available Patient Signature
Doctor's Signature:	No Signature Available Doctor Signature

AUG 2013
NSBDE